



E X P E C T M O R E

2026 Annual Benefit Notices

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Notice of Special Enrollment Rights

If you decline enrollment for medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the medical benefits under this Plan mid-year if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your eligible dependents' other coverage). However, you must request enrollment within 30 days after your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any eligible dependents within 30 days after the marriage, birth, adoption, or placement for adoption. You also may enroll in medical benefits mid-year if you or your eligible dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. Assuming the applicable notification and election timeframes described above are met, your election change will be effective on the later of the date of the event or the date that you notify the plan of the change (For example, loss of coverage, birth, marriage date) except, in cases you are dropping a spouse or a domestic partner, a new spouse or domestic partner cannot be added until the beginning of the following month.

To request enrollment under these HIPAA special enrollment rules or to obtain more information, including possible extensions of time for enrollment in certain circumstances, contact Engage PEO at 888-780-8807

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Initial Notice of COBRA Continuation Rights

COBRA

Federal law requires that most employers who sponsor group health plans (medical, dental, vision, and health care flexible spending account plans) offer employees and eligible dependents the opportunity to purchase a temporary extension of these plans at group rates in certain instances where coverage under the plan would end. Under COBRA, employees and beneficiaries have the right to choose continuation coverage under certain qualifying events.

Employees also have the right to choose continuation coverage under the Uniformed Service Employment and Reemployment Rights Act (USERRA) as amended, while on a military leave of absence. An election of COBRA will be deemed to be an election of USERRA coverage and both coverage(s) will run concurrently. The cost of USERRA coverage will be the same as the cost of COBRA coverage. Refer to the USERRA section below for more information.

When COBRA Coverage Ends

COBRA Coverage will end if:

- The company stops providing coverage for all employees;
- You or your eligible dependents do not pay your premiums on time;
- You or your eligible dependents become covered by another group health plan;
- You or your eligible dependents become covered by Medicare; or
- You or your eligible dependents extended COBRA coverage to 29 months due to disability but are no longer considered disabled.

Initial Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan.

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, see below or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The work-site employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

For a qualifying event due to divorce or legal separation, a copy of the final divorce decree or court order regarding the legal separation may be requested as documentation. For a qualifying event due to losing eligibility for coverage as a dependent child, verification of the dependent child's limiting age may be requested.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the Medicare effective date.

For example, if a covered employee's Medicare enrollment becomes effective 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date his Medicare coverage was effective, which is equal to 28 months after the date of the termination of employment (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be given within 60 days of the date that the qualified beneficiary has been determined to be disabled by the Social Security Administration to:

COBRA Administrator, for more information about your COBRA administrator please contact your benefits department.

A copy of the disability determination letter from the Social Security Administration may be requested as documentation of the qualifying event.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Notice must be given within 60 days of the date that of the second qualifying event to the Plan Administrator.

Special Rule for Health Care Flexible Spending Account

You, your spouse, and/or your dependent may only elect COBRA coverage if the maximum benefit available under the health care flexible spending account for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan Year. COBRA coverage for the health care flexible spending account ceases at the end of the plan year in which the qualifying event occurs.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have any questions

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

Plan Contact Information

Additional information regarding the plan may be obtained from the COBRA plan administrator or group health plan administrator, please contact your benefits department to obtain more information.

COBRA and USERRA

If you take military leave under USERRA, whether for active duty or for training, you are entitled to continue medical coverage for up to 24 months as long as you give your employer advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from your employer, does not exceed five years (with certain exceptions). If the entire length of the leave is 30 days or less, you will not be required to pay any more than your regular contribution (if applicable) for coverage. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost (including employer contributions).

If you take military leave and your coverage under the Plan is terminated, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether any exclusion or waiting period applies to health plan coverages. However, USERRA permits a health plan to impose an exclusion or waiting period for an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services. If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage for the remainder of the COBRA coverage period.

These procedures are intended to comply with USERRA's final regulations. If there are any inconsistencies in USERRA's final regulations and these procedures, USERRA's final regulations will control.

Health Insurance Marketplace

NOTE: Your Health Insurance Exchange Notice (Notice of Coverage Options) is generally included in your New Hire packet and available by request to your work-site employer.

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-based Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 8.39% (for 2024; indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% (for 2024; indexed annually) of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When can I Enroll in Health Insurance Coverage Through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800- 318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer

or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/> for more details.

How can I get More Information?

For more information about your coverage offered through your employment, please contact your work-site employer or Engage PEO, as applicable.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by your Employer

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide certain information from your work-site employer.

Please contact your work-site employer directly to receive a copy of the Healthcare Insurance Marketplace exchange part B notice information.

An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All Stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the applicable deductibles and coinsurance amounts can be found in the Schedule of Copays of the plan selected.

If you would like more information on WHCRA benefits, contact your benefits department.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1- 877-**

KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Michelle's Law

Michelle's Law, enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

Newborn's and Mother's Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Preventive Care Services

The medical plans are non-grandfathered and as such are subject to rules under the ACA for covering certain types of preventive care services without any cost-sharing requirements.

The Plan follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. A full list of the

covered services is available at www.HealthCare.gov/center/regulations/prevention.html. Except as otherwise noted, the Plan is not required to cover preventive services until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an “A” or “B” recommendation for a preventive service on February 15, 2023, the Plan is not required to cover it until January 1, 2025. For the most up-to-date list of preventive services that are covered by the Plan, contact your insurance carrier directly by calling the number on the back of your medical identification card.

Notice of Patient Protections

Some of the Plan’s health plans allow the designation of a medical primary care provider (PCP). You have the right to designate any primary care provider (PCP) who participates in that plan’s network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider (PCP). Until you make this designation, the plan may designate one for you. For information on how to select a primary care (PCP) and for a list of the participating primary care providers, contact the carriers directly at the number on the back of your identification card or call the Engage PEO Benefits Department at 1-888-780-8807. You do not need prior authorization from the Plan’s health plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the carrier(s) directly at the number on the back of your medical ID card or the Engage PEO Benefits Department at 1- 888-780-8807. Additionally, coverage for emergency services in a hospital must cover emergency services provided at hospitals that are out-of- network without any administrative requirements or limitations more stringent than those imposed on in-network hospital emergency services.

Participant copays or coinsurance amounts cannot be higher than that imposed on in-network emergency services. However, participants may be required to pay any excess amount that the out-of-network hospital charges over the amount the plan or insurer pays to its in-network hospitals. The plan may not require preauthorization if the plan provides benefits for emergency services. For more information on coverage for emergency services contact the carrier(s) directly at the number on the back of your medical ID card or call the Engage PEO Benefits Department at 1-888-780-8807.

Genetic Information and Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

If you think you’ve been wrongly billed, contact the U.S Centers for Medicare & Medicaid Services (CMS). The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit www.michigan.gov/difs for more information about your rights under Michigan laws. The Department of Insurance and Financial Services responsible for the Michigan version of the law can be contacted at 1-877-999-6442.

No surprises Act

Your rights and protections against Surprise Medical Bills.

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "Balance Billing" or "Surprise Billing"

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services.

Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care— like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from Balance Billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post- stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of- network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance Billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly. Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers
- Based what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the U.S Centers for Medicare & Medicaid Services (CMS). The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit www.michigan.gov/difs for more information about your rights under Michigan laws. The Department of Insurance and Financial Services responsible for the Michigan version of the law can be contacted at 1-877-999-6442.

Mental Health Parity and Addiction Equity Act (MHPEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally prevents group health plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Under MHPAEA, the financial requirements (such as deductibles and co-pays) and treatment limitations applicable to MH/SUD benefits cannot be more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. MHPAEA's parity requirements apply to both number of visits as well as medical management standards. MHPAEA generally applies to employers with 50 or more employees. However, ACA builds on MHPAEA and requires some plans to cover MH/SUD services as an essential health benefit. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements

Parity requirements

MHPAEA contains the following parity requirements:

- The financial requirements (such as copays, deductibles, out-of-pocket maximums) that apply to the MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to the medical and surgical benefits.
- Treatment limitations (frequency of treatment, number of visits, length of coverage) cannot be more restrictive on MH/SUD than those applied to other medical benefits.

Other benefits that MHPAEA imposes parity requirements on include medical management standards, formulary designs for prescription drugs, methods for determining reasonable and customary charges, exclusions based on a failure to complete a course of treatment and restrictions based on facility type or provider specialty.

MHPAEA requires comparative analysis to ensure plans are compliant. In most cases, carriers will help prepare comparative analyses for employer-sponsored health plans. However, the final rule requires the comparative analyses for ERISA-covered plans to also include a plan fiduciary's certification that they have engaged in a prudent process and monitored their service provider(s).

Disclosure requirements

MHPAEA requires plans to make information available to participants with respect to MH/SUD benefits regarding the criteria for medical necessity and reason for claim denial(s). In addition, upon request, ERISA plans must provide participants with information about processes, strategies, evidentiary standards, and other factors used to determine compliance with MHPAEA. To avoid penalties, employers should respond to these requests within 30 days.

Qualified Medical Child Support Orders (QMCSO)

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA § 609(a)). A "medical child support order" (MCSO) is an order, decree, or judgment of a court of competent jurisdiction that: (i) is made pursuant to a state domestic regulations law (including a community property law) and provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to the child under the group health plan; or (ii) enforces a law relating to medical child support described in Social Security Act § 1908 which respect to a group health plan.

A QMCSO is a medical child support order that (i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, (ii) provides certain required information with respect to the order, and (iii) does not require the Plan to provide benefits not otherwise available under the Plan, except to the extent necessary to meet the requirements of Social Security Act § 1908.

The order must clearly state:

- the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order (however, the name and mailing address of the state or political subdivision thereof may be substituted);
- a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner

- in which such type of coverage is to be determined;
- the period to which such order applies; and
- each plan to which such order applies.

Certain procedural requirements are prescribed. The Plan Administrator must promptly notify the participant and each alternate recipient of the receipt of a medical child support order and the Plan's procedures for determining whether medical child support orders are QMCSOs. Within a reasonable period after receipt of the order the Plan Administrator must determine whether the order is a QMCSO and notify the participant and each alternate recipient of the determination. Each component plan that is a group health plan must establish reasonable procedures to determine whether medical child support orders are QMCSOs. Such a procedure must be in writing, provide notification to each person specified in a MCSO as eligible to receive plan benefits, and permit an alternate recipient to designate a representative for receipt of copies of notices with respect to the MCSO.

Special Rights on Childbirth

With respect to component benefit plans that offer such services, note that group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Discrimination based on Health-Related Factors Prohibited

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any participant or dependent in the terms of eligibility to participate in the plan based on a health-related factor. Accordingly, benefits provided under your plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The plan may (i) limit or exclude benefits that are experimental or are not medically necessary (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit. Provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals and are not just directed at an individual based on a health-related factor.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Terms used in this section are as defined in the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy Regulations") or 45 C.F.R. Part 160 and Subparts A and C of Part 164 ("HIPAA Security Standards"). The Plan may disclose protected health information to the Company, to enable the Company, as Plan Sponsor, to carry out plan administration functions, or as otherwise permitted by HIPAA Privacy Regulations. The Plan will not use or disclose protected health information that is genetic information for underwriting purposes.

Access to Medical Information

The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

- the Plan Administrator;
- members of the benefits, legal, finance, information system, audit, accounting, and human resources department of the Plan Sponsor to the extent they perform functions with respect to the Plan; and
- such other individuals or classes of individuals identified by the Plan's privacy officer as necessary for the Plan's administration.

The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that

it agrees to:

- Not use or disclose protected health information other than as permitted or required by the Plan documents or as required by law;
- Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Plan Sponsor becomes aware;
- Make protected health information accessible to covered persons in accordance with the HIPAA Privacy Regulations;
- Allow covered persons to amend or correct their protected health information in accordance with the HIPAA Privacy Regulations;
- Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;
- Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;
- Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information, or if not feasible, restrict access and uses as required by the HIPAA Privacy Regulations;
- Ensure that any agents, including a subcontractor; of the Plan Sponsor to whom it provides protected health information also agree to these same restrictions.
- Ensure that adequate separation between the Plan Sponsor and Plan is established as required under the HIPAA Privacy Regulations; and
- Restrict the use of protected health information by those individuals identified above for plan administration functions within the meaning of the HIPAA Privacy Regulations.

Notwithstanding the foregoing, the Plan may disclose to the Plan Sponsor the following types of information:

- Summary health information may be disclosed to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.
- Information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- Information provided pursuant to an authorization within the meaning of section 164.508 of the HIPAA Privacy Regulations.
- De-identified information, as defined under the HIPAA Privacy Regulations.

Non-Compliance: In the event of noncompliance with the restrictions above by a designated employee or other individual receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such person shall be filed with the Plan's privacy officer

HIPAA Security Standards

Safeguards. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

Agents. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate safeguards to protect such information.

Security Incidents. The Plan Sponsor will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

Adequate Separation. The Plan Sponsor will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Plan Sponsor, in support of the requirements of this section.

Application. The provisions of this section only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

Medical Reimbursements, Stipends or Incentives. The Plan does not allow or support the use of medical compensation reimbursements, stipends or incentives that would encourage employees to waive out of the employer sponsored benefit plans. The use of these incentives can directly conflict with ACA, Federal Medicare and other regulations and will not be supported.

HIPAA Privacy Issues

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

HIPAA Privacy Notice This notice describes how your protected health information or PHI may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act (HIPAA).

Uses & Disclosures of Your Information

The group health plans may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plans. For example, the Plans may use your PHI for management activities related to the Plans, including auditing, fraud and abuse detection, and customer service. The Plans also may use or disclose your PHI in order to pay your claims for benefits. For example, the Plans may use your information to make eligibility determinations and for billing and claims management purposes.

GINA. Note that the Genetic Information Nondiscrimination ACT (GINA) prohibits using PHI that is genetic information for underwriting purposes.

Plan Sponsor. In addition, the plan administrator may disclose your PHI to the company so that the company can perform administrative functions on behalf of the Plan, such as facilitating claims or appeals.

Substance Use Disorder Records. If you were treated by a health care provider or program that is subject to the federal privacy laws under 42 CFR Part 2 and you give consent for your Part 2 treatment records to be used and disclosed for purposes of treatment, payment, or health care operations, the Plan may rely on such consent for its own future uses and disclosures of such records for treatment, payment, or health care operations under the Plans.

Substance use disorder treatment records received from a programs subject to 42 CFR Part 2, or testimony relaying the content of such records, may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless: (1) you provide written consent; or (2) the Plans receives a court order accompanied by a subpoena or other legal requirement compelling disclosure and you, or the holder of your substance use disorder treatment record, are provided notice and an opportunity to be heard.

Other Privacy Laws. Under the HIPAA privacy and security rules, the plans may be required to comply with other more stringent state or federal privacy laws that require grater limits on disclosure of your PHI, such as 42 CFR part 2 related to substance use disorder treatment records.

Exceptions. The plans also may use or disclose your PHI where required or permitted by law, federal law, under the Health Insurance Portability and Accountability Act of 1996 generally permits health plans to use or disclose PHI for the following purposes:

- Where required by law;
- For public health activities;
- To report child or domestic abuse;
- For governmental oversight activities;
- Pursuant to judicial or administrative proceedings;
- For certain law enforcement purposes;
- For a coroner, medical examiner, or funeral director to obtain information about a deceased individual;

- For organ, eye, or tissue donation purposes;
- For certain government-approved research activities;
- To avert a serious threat to an individual's or the public's health or safety;
- For certain government functions, such as related to military service or national security; or
- To comply with Worker's Compensation laws;
- To a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- To notify a family member of other individual involved in your care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

Authorization. For any other uses and disclosures of your PHI, the plans will obtain your written authorization.

Marketing/Sale of PHI/Psychotherapy Notes. The plans will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes.

Revoke. You may revoke this authorization in writing at any time, provided the plans has not yet taken action in reliance on your authorization.

Your rights with respect to your health information

You have several rights with respect to your PHI, which are described below. Please call privacy contact listed below if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plans generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plans in a designated record set or to request an electronic copy. The Plans may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plans maintains in a designated record set. The Plans may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plans.
- You have a right to request an accounting of disclosures the Plans has made of your PHI for the six years prior to your request, except for disclosures you have authorized or disclosures for routine treatment, payment, or health care operations of the Plans.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

Our duties with respect to your individually identifiable health information

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices. The Plan is required to abide by the terms of this notice. The Plan is required to notify you if there is a breach of your unsecured PHI. The Plan reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. If there is a material change to any provisions of this notice, the Plan will distribute a revised privacy notice.

Questions?

Contact If you have questions or would like more information about the Plan's privacy policies, you may contact the Engage PEO Benefits Department, 1-888-780-8807.

Complaints If you believe your privacy rights have been violated, you may file a complaint with the Plans or the Secretary of the U.S.

Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

Transparency in Coverage Notice

You are receiving this notice because you requested a cost estimate for an item or service. This notice contains important information about the cost estimate and information on the amount you may ultimately be required to pay for this item or service.

What should I do with this notice?

Read this notice carefully along with the cost estimate. You may need to request a new cost estimate as you obtain new information, such as information on additional items or services you will receive as part of your treatment.

What are the key terms?

- An **Allowed Amount** is the maximum amount your health plan will pay for a covered item or service furnished by an out-of-network provider.
- **Cost-Sharing** is your share of costs for a covered item or service that you must pay (sometimes called “out-of-pocket costs”). Some examples of cost-sharing are deductibles, coinsurance, and copayments. This term does not include other costs you may be responsible for, such as premiums, balance billed amounts for out of network providers, or the cost of services not covered by your health plan.
- A **Covered Item or Service** is an item or service that your health plan will pay, either in whole or in part, under the terms of your health plan.
- An **Out-of-Network Provider** is a provider that does not have a contract with your plan to provide services at pre-negotiated rates.
- **Prerequisites** are certain requirements your health plan may impose on you or your provider so that it can determine whether a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary before it will provide benefits for related items and services. Prerequisites include prior authorization, concurrent review, and step-therapy or fail-first requirements.

Other common medical and insurance terms, including definitions of deductibles, coinsurance, and copayments, can be found in the Uniform Glossary of Coverage and Medical Terms <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits>

Important information about your cost estimates

This estimate is designed to provide you with information about the cost of an item or service before you receive care.

However, this estimate has certain limitations that you should consider before making any decision to obtain the item or service

1. If you are treated by an out-of-network provider, after paying the cost-sharing amount determined by your health plan, you may still receive a bill for the difference between the amount the out-of-network provider charges for the item or service and the amount paid by your health plan. This is called balance billing, and this amount is not included in your cost estimate.
2. The actual charge for the item or service may be different than the cost estimate, depending on the actual care you receive. For example if your physician provides additional services during your visit, your charges could be more than the cost estimate. This is one reason why it is important to discuss with your provider both before and during your visit which items and services you will receive and to request a new cost estimate if new information becomes available.
3. This cost estimate is not a benefit determination or guarantee of coverage for the item or service for which you requested information. For example, your plan may need to determine whether the item or service is medically necessary in your case before making a payment. You should follow your health plan's process for filing a claim for benefits and contact your health plan to help determine if there are any additional requirements that apply to you as part of that process.

Prerequisites (include the applicable portions of this section only if the item or service is subject to the prerequisite in question)

- Select Plan Term: Prior authorization. Prior approval or precertification

Your health plan must decide whether this item or service is medically necessary *before* it will cover this item or service. This is called [SELECT PLAN TERM: prior authorization, preauthorization, prior approval or precertification]. Your health plan may impose additional costs if you or your provider do not submit this item or service for [SELECT PLAN TERM: prior authorization, preauthorization, prior approval or precertification] before the item or service is provided.

- Concurrent review

Your health plan may require a review during an ongoing course of treatment to determine whether the plan will continue to cover the item or service. This is called concurrent review. Your health plan may cease covering treatment if you or your provider do not submit this item or service for concurrent review within a specified time period after beginning treatment

- Select Plan Term: Step-therapy or fail-first requirement

Your health plan will not pay for higher-cost therapies without evidence that certain lower-cost therapies have not been effective for the participant, beneficiary, or enrollee (these are known as fail-first policies or step-therapy protocols). You may be required to try a lower-cost alternative before your plan will cover this particular item or service.

What if I need more information?

Contact your insurance carrier or your benefits department

Medicare Creditable Coverage

Important notice from your employer about your prescription drug coverage on your medical plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are 2 important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- 2- ENGAGE PEO has determined that the prescription drug coverage offered by ENGAGE PEO Benefit Plan through AETNA, KAISER PERMANENTE, SELECT HEALTH, UNITED HEALTH, ANTHEM and BLUE CROSS BLUE SHIELD is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare Drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7. However, if you lose your current creditable coverage with your employer, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug plan?

If you decide to join a Medicare drug plan, your current Engage PEO coverage will not be affected as long as you do not drop your coverage. Your prescription drug coverage is provided through your medical plan which includes both medical and prescription drug benefits. You may keep this coverage even if you elect Part D and this plan will coordinate with Part D coverage although the Engage PEO plan may be primary in that coordination. If you do decide to join a Medicare drug plan and drop your coverage with Engage PEO, which includes your medical and prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back until the next Annual Enrollment period with Engage PEO.

When will you pay a higher premium (penalty) to join a Medicare Drug plan?

You should also know that if you drop or lose your current coverage with ENGAGE PEO and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than

the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice of your current prescription drug coverage. Please contact the Engage PEO Benefits Department at 1-888-780-8807 for further information about this notice. You may also contact Aetna Member Services for additional information about your current prescription coverage at 1-866-551-6664. Kaiser Permanente at 800-464-4000(English)or 800-788-0616(Spanish), Select Health at 800-538-5038, United Healthcare at 866-801-4409, Anthem 800-578-2142 and Blue Cross Blue Shield 800-676-2583.

NOTE: You'll get this notice each year. You will also get it during the next annual enrollment period, and if this coverage through Engage PEO changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage... More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug coverage

Visit www.medicare.gov Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-722-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 5, 2025
Engage PEO
Contact-Position/Office: Engage PEO Benefits Department
Address: 4211 W Boy Scout BLVD, STE 500
Tampa, FL 33607
Phone Number: 1-888-780-8807